UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
INDIANAPOLIS DIVISION

K.C., *et al*,	
Plaintiffs,	
vs.	CAUSE NO. 1:23-cv-00595-JPH-KMB
	Indianapolis, Indiana
THE INDIVIDUAL MEMBERS OF THE MEDICAL LICENSING BOARD OF INDIANA, *et al*,	June 14, 2023
	1:30 p.m.
Defendants.	

Before the

HONORABLE JAMES PATRICK HANLON

PRELIMINARY INJUNCTION

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(*In open court*)

THE COURT: Good afternoon, everyone. We are on the record in Case No. 1:23-cv-595, K.C., et.al. vs. The Individual Members of the Medical Licensing Board of the State of Indiana in Their Official Capacities, et. al. We are here for a hearing on the plaintiffs' motion for a hearing on preliminary injunction.

I would ask for lead counsel, beginning with the plaintiffs, to please introduce themselves for the record, as well as their co-counsel. And you are free to, but don't have to, introduce any party representatives who happen to be in the courtroom as well.

Mr. Falk.

MR. FALK: Thank you, Your Honor. Ken Falk from the ACLU of Indiana representing the plaintiffs. With me from the ACLU of Indiana are my co-counsel Gavin Rose and Stevie Pactor. And with me from the ACLU offices in New York are Chase Strangio and Harper Seldin. Thank you.

THE COURT: Okay. Thank you.

MR. FISHER: Good afternoon, Your Honor. Tom Fisher, solicitor general of Indiana on behalf of defendants. With me at counsel table, James Barta, deputy solicitor general; Melinda Holmes, deputy attorney general; Razi Lane, deputy attorney general.

THE COURT: Okay. Thank you. The parties had

originally requested that the hearing be limited to argument with no evidence presented, and that was affirmed at the June 5th, 2023 status conference. In preparation for the hearing I have reviewed the parties' stipulated facts that were filed at Docket 51; the briefing; as well as voluminous exhibits filed by both sides in support of the briefing; and there also was a recently filed defense motion to exclude the opinions of plaintiffs' experts that was filed on June 12th, 2023.

The parties had requested 45 minutes per side for their presentations, so that is how we will proceed. I have built in some extra time to account for questions that I may have.

So since the plaintiffs, of course, carry the burden, they will go first. Mr. Falk, I assume you are going to reserve some time for rebuttal?

MR. FALK: Yes, Your Honor. Hopefully I will be able to reserve 15 minutes or so for rebuttal.

THE COURT: Okay.

MR. FALK: But before I start my presentation, I would like to make a motion. We would like to move to strike the motion to exclude that you just referred to, Docket 63, that was filed after business hours on Monday. Under the local rules, of course, we have 14 days to respond. We did not want to generate any more paper in this case, and therefore I'm

making this oral motion for a number of reasons.

First, during our on-the-record conference that the Court alluded to on June 5th, the parties agreed that all of the evidence that was being submitted to this court would be admitted, with the Court assigning it the weight that it deems appropriate. The State is now contradicting that explicit understanding by filing this motion, and it simply cannot go back on its stipulation this way.

Second, Your Honor, we filed our preliminary injunction memorandum, as you know, on April 21st, with the declaration of our three experts attached. Defendants filed their memorandum -- opposed it -- on June 2nd, 43 days later. Defendants conducted the depositions of the three experts, our three experts, ending on May 18th -- May 19th, excuse me. They had ample time, two weeks, prior to June 2nd to file any motions directed towards the experts that we have, and there is no excuse for waiting until the eve of this hearing to file to strike, especially given the fact that the law is scheduled to go into effect in two weeks.

Third, Your Honor, the case law is clear, of course, that a preliminary injunction motion, or any matter that is being heard by the Court, as opposed to a jury, *Daubert* motions are not favored. The judge is the gatekeeper and can assess the evidence and determine what weight should be given. The case law on this is voluminous. I actually have a case of

yours, the ***Hitachi Astemo*** case at 2022 Westlaw, 3369263 from last year that says that, along with many citations.

That is precisely why we spend time in our reply memorandum addressing the weakness of the defendants' experts. The defendants could have done so in their response memorandum, but instead they have filed a new 35-page memoranda in opposition to our preliminary injunction request and have labeled it a motion to exclude. In the memorandum they end up saying that if the experts are not excluded, that they should be given no weight. Well, that's an argument that should have been made when they filed their response. Moreover, the State is using this motion to introduce new evidence in the form of exhibits, all of which existed prior to June 2nd.

Briefly put, Your Honor, they had their chance to argue against the plaintiffs' experts that was in their response that was due long after they deposed those experts, and they should not be given another bite of the apple at this point. We are happy to reply to the substance of the motion because we do not think it is well taken. If the Court wishes a substantive response, we would like a week to file that. But at this point, given where we are, we think that the motion to exclude should be struck.

Thank you.

THE COURT: Okay. All right. Thank you. So I'm going to take that under advisement, and Mr. Fisher, of course,

will have an opportunity to respond when he speaks. I will say that the parties had worked very hard with the Court in coming up with what was an agreed-upon expedited schedule for briefing and discovery and other matters so that we would be full ready to give presentations at this hearing, which was scheduled a long time ago, so the filing of the motion on June 12th did come as a surprise to me as well. It also does address many issues that could have been addressed in the response brief. But that being said, there are many important issues. That is an important issue, but there are many other important issues that I know both the parties have put a lot of work into, so I will hear what Mr. Fisher has to say when he gets up to give his presentation, but I will plan to take the motion to strike under advisement. I don't want us to get overly sidetracked with that at this hearing this afternoon. Thank you.

MR. FALK: Thank you, Your Honor. And with having said that, pursuant to the agreement that we reached in our conference with the Court, my understanding is, is that both parties have agreed that all of the evidence that has been tendered to the Court to this point, with the exception of the evidence attached to the motion to exclude our experts, is before the Court, and I would move all of that evidence in, with the Court to decide the weight to be given, again with the exception of the motion, so at least tendered evidence attached to the motion to exclude.

THE COURT: Subject to that limitation, I will go ahead and admit that evidence at this time.

MR. FALK: Thank you, Your Honor.

THE COURT: Thank you.

MR. FALK: As far as my presentation is concerned -- thank you -- we are two weeks away from the effective date of Senate Enrolled Act 480, a statute that not only will stop the care that the minor plaintiffs and other transgender youth in Indiana are receiving, and might otherwise receive in the future, but will force them to experience irreversible physiological changes that are inconsistent with their gender identities. This going backwards, developing characteristics of the wrong gender, will be disastrous. S.E.A. 480, Senate Enrolled Act 480, is an odd law. It bans the care that the minor plaintiffs are receiving and that hundreds of other transgender Hoosier adolescents are receiving, despite the fact that the care they are receiving is the standard of care endorsed by every major medical and mental health organization in the United States: the American Medical Association, the American Psychiatric Association, the American Psychological Association, the American Academy of Pediatrics, the Endocrine Society, the Pediatric Endocrine Society, and the American Academy of Family Physicians, among others. It bans this care despite the fact that the gender-affirming medical care is vitally necessary to stem the serious side effects of gender

dysphoria, a well-recognized mental disorder that causes depression, anxiety, self-harming behavior, suicidal ideations, and hospitalization, all symptoms manifested by the minor plaintiffs in this case.

S.E.A. 480 bans this gender-affirming care, despite the fact that every court that has faced similar statutes to this one has preliminarily enjoined them, finding the plaintiffs are likely to prevail in their claims, both constitutionally and statutorily, and that the plaintiffs are threatened with obvious irreparable harm.

S.E.A. 480 bans this gender-affirming care despite the fact that the law is explicit that the exact same care that will be denied to the plaintiffs, what we call generically puberty blockers and gender-affirming hormones, remains available to treat conditions that will afflict adolescents who are not transgender. The treatment is just not available to transgender youth for their gender-affirming care.

And most of all, S.E.A. 480 is an odd law because it bans gender-affirming care despite the fact that it works. We know that from the research, the extensive clinical experience of our experts, and probably most importantly we know it because it has clearly lessened the debilitating symptoms of gender dysphoria for the plaintiffs, K.C., M.W., A.M., and M.R., and many other transgender youth in Indiana.

THE COURT: Let me ask you one question there --

MR. FALK: Of course.

THE COURT: -- on your statement that we know it works. Obviously the evidence that the Court should take into account is very hotly contested in this case. The defendants point out, of course, that the results of randomized controlled trials would be the best evidence to have to most accurately consider safety and efficacy of these treatments. Given the lack of that research-based data, would you agree that the safety and the efficacy is largely uncertain and unknown?

MR. FALK: No, Your Honor. Random controlled trials cannot be done here. You cannot tell a parent we're going to give treatment to Child A, but we're not going to give your child treatment. And I think all of their experts, when asked in depositions, conceded that this is not an area where random controlled trials would be ethical. What we have, however, is many, many studies and we have experts who have talked -- who have treated thousands of adolescents and the studies all point that this is in fact the best care available. The WPATH standards and the Endocrine Society standards are based on research and they're based on studies and they're clinically backed, so I think what we're dealing with here are standards that definitely have been proven and have been established through clinical practice.

Conversely, the State offers nothing on the other side. There is no other treatment for gender dysphoria other

than this -- the standards of care that all of these medical organizations have endorsed. We're not in a situation where we have to choose between two different types of care. The only research-backed, science-backed care that is available are these standards of care and that is exactly what is being delivered through Riley to three of the plaintiffs and through Mosaic to one of the plaintiffs and it's what's being delivered throughout the United States to thousands and thousands of adolescents.

Now, what the State argues is that this standard of care treatment is dangerous and unsupported by adequate science, but that's been repeatedly rejected in ***Ladapo***, in ***Brandt***, and ***Eknes-Tucker***, dealing with very similar statutes, as well as in ***Fain***, ***Kadel***, and ***Flack*** dealing with state health or Medicaid plans excluding gender-affirming care. And arguing against this standard of care treatment seems to be a difficult task, if not impossible, given that every major mental health and medical organization supports the protocols. Moreover, as I noted, we have submitted declarations from three experts in the field, Drs. Turban, Karasic, and Shumer, who not only have done extensive research in this area that supports gender-affirming care and are aware of a vast majority of studies supporting the care, but have the clinical experience with thousands of patients to demonstrate that this actually works.

And given the motion that was just filed, I would like to focus for a second on our experts. Dr. Karasic, who was credited as an expert in *Ladapo*, is a psychiatrist, he is a professor emeritus at the University of California San Francisco medical school, he has been working with gender dysphoric patients for 30 years. For 17 years he was a psychiatrist at the Dimensions Clinic for transgender youth in San Francisco. He has seen thousands of patients. He is the co-author of the WPATH standards of care, Edition 8. He has developed a special certification in transgender health that has helped train over 2,000 health providers to make this care. He is the consultant for transgender care for both the California Department of State Hospitals and the California Department of Corrections Rehabilitation. He has also served as an expert consultant for the United Nations Development Programme on international issues concerning transgender care.

Dr. Shumer, who has also been credited as an expert in *Ladapo*, is a pediatric endocrinologist. He has been treating adolescents with gender dysphoria since 2015 when he created the child and adolescent center -- gender clinic, excuse me, at the Mott Children's Hospital, which is part of Michigan Medicine at the University of Michigan where he still serves as a clinical director. He is an assistant professor of pediatrics at the university. He has published extensively on gender dysphoria in peer review journals, and that is the focus

of his work. He has personally treated over 400 patients at the clinic, and he has co-authored textbooks on medical management of transgender persons.

Dr. Turban, our last expert, is a psychiatrist and assistant professor of child and adolescent psychiatry, again, at the University of California, San Francisco medical school. He is the director of the gender psychiatry program there. He also has conducted an enormous amount of research on mental health of transgender youth and youth experiencing gender dysphoria, and he is published extensively on the subject in peer-reviewed journals.

Even without their obvious scholarship, these persons are experts based on their clinical experience. This contrasts greatly with the defendants' so-called experts who venture opinions that are far outside the mainstream and based on virtually no scholarship or expertise and as we have argued are entitled to little weight.

We have two endocrinologists, Dr. Hruz and Weiss, who have never treated a patient for gender dysphoria. Dr. Hruz has never done any research in the area, and his opinions have specifically not been credited in *Ladapo* and *Kadel*. With the exception of a letter to the editor, Dr. Weiss's limited writings -- I believe six -- on gender dysphoria have appeared only in religiously-affiliated publications, and Dr. Weiss holds the opinion, expressed in his deposition, that the

American Medical Association is a politically-motivated organization, and that all of the groups endorsing gender-affirming care, all of the medical and mental health groups in the United States, have been taken over by group think and social contagion.

The State proffers Dr. Kaliebe, a psychiatrist who also has not done any research or published any articles concerning gender dysphoria and has treated only about 13 minors with gender dysphoria in a career that stretches over 20 years.

We have an Australian psychologist proffered, Dr. Kenny, who also has done no original research. He sees only patients whose parents are convinced their children have been misdiagnosed with gender dysphoria, which he doesn't necessarily believe exists, but he believes to the extent that people claim gender dysphoria, it's caused by social contagion and he explains the fact that every major medical and mental health group of the United States approves the standards of care as the result of the transactivist lobby and the transactivist medical industry pushing gender-affirming care.

THE COURT: I have a question for you at this point.

MR. FALK: Of course.

THE COURT: So even if these experts -- and of course in the briefs there is a lot of mutual accusations going to the qualifications of the experts, but it strikes me that the

experts on both sides are reasonably well credentialed, and even if the defense experts, one or more of them, don't have experience directly tied to treating the procedures that are prohibited by S.E.A. 480, wouldn't you agree they at least have experience that is relevant of a nature that would qualify them as experts so that I would consider their opinions?

MR. FALK: Not when it comes to treating gender dysphoria in adolescents, Your Honor. Dr. -- as I said, Dr. Hruz was specifically not credited in *Ladapo* and *Kadel* because he has no experience. Dr. Kaliebe has seen 13 persons in 20 years. Dr. Kenny doesn't even believe that gender dysphoria exists, and she is treating persons with a form of therapy that she admits is actually band in three Australian states because it is deemed to be conversion therapy. We have Dr. Cantor who receives 80 percent of his income serving as an expert, but he doesn't specialize in gender dysphoria. He specializes in atypical sexual attractions, like pedophilia. He has not performed any research on gender dysphoria. He has treated only eight minors with gender dysphoria and has not treated anyone under the age of 16. He -- in *Eknes-Tucker*, after seeing these qualifications, the Court said he was entitled to very little weight.

What the experts have done is they have cherry-picked through articles and regurgitated what they think those articles say. But as we noted in our brief, that simply is not

the role of an expert. Someone cannot go into an area where they have no expertise and find literature and claim they have the expertise because they repeat the findings or what they believe to be the findings of literature. This is not the function of an expert.

THE COURT: So I have a question for you here. I think that the case you referred to was the case that was in either Arkansas or Alabama, the case that --

MR. FALK: Yes, both are -- one in Arkansas and one in Alabama, yes.

THE COURT: And wasn't that a bench trial?

MR. FALK: That was a preliminary injunction on a bench trial, yes.

THE COURT: Okay. On a bench trial, though?

MR. FALK: Yes.

THE COURT: So here the parties didn't want an evidentiary hearing, so I'm left with a paper record of, as I said, experts on both sides that each arguably appear to be reasonably well qualified, even if they don't have experience directly in this area, which I don't think is a requirement for the qualification, but my question would be, given the allegations on both sides, without the opportunity to observe the experts as they testify, to observe their demeanor and hear them under cross examination, how should I go about weighing their comparative qualifications --

MR. FALK: Sure.

THE COURT: -- without the benefit of that?

MR. FALK: Well, I guess I have two responses. One is to the extent that we have experts who have had years and years of actually treating adolescents with gender dysphoria, who have the clinical experience, that is entitled to an enormous amount of weight, as opposed to defendants' experts who have virtually no experience. Some have no experience at all. If you find, for instance, that we have Dr. Cantor who has nothing to do with gender dysphoria in terms of training, in terms of research, there is no reason to credit what he says. There is no reason to credit what Dr. Kenny says who doesn't even believe in gender dysphoria and thinks it's all a big conspiracy. There is no reason to credit Dr. Hruz or Dr. Weiss who have never treated a patient with gender dysphoria and have no research experience. However -- I'm sorry.

THE COURT: When you talk about their views about the underlying subject, the defense, of course, has made similar allegations that your experts shouldn't be taken into account because they are infected with bias. That is the allegation that the defense has made about your experts. So I'm not sure that it's very helpful for me to hear both counsel mutually saying how the other side's experts are not credible because of a view that they supposedly hold, which hasn't been, again,

borne out and really tested in the crucible of cross examination.

MR. FALK: And I guess my second response, Your Honor, is that even if you credit all of the witnesses, you are still left with a procedure or a standard of care which is adopted by every major medical organization in the United States and you are still dealing with parents who bring a child to a doctor and the doctor says here is the standard of care by all of these organizations and you are now telling the doctor and the parent, and most importantly the child, you can't get this care and there is nothing that allows a state to do that. Even if there is a legitimate disagreement, which I don't think there is, but even if there is a legitimate disagreement as to this care, we have to recognize it is the standard of care, and the State has no constitutional ability to intervene in that. So I would say that regardless of the strength of the experts -- and I think our experts are measurably stronger with much more experience and have been credited by other courts because of that experience and that knowledge, but even without that, we're still having the State of Indiana saying we don't care that every major medical organization and mental health organization in the country says this is okay, you can't do it, and I think that's where we are.

THE COURT: And when you say that the State has no constitutional ability to intervene, in your view, is the

problem that the State is regulating the procedures at all, or is it the extent of the regulation? So, for example, if the State had codified WPATH's guidelines or the guidelines that Riley follows, would that be constitutional?

MR. FALK: I think so, Your Honor. I mean I think we are not concerned here with the precise nature of the regulation because what we're dealing with here is a total prohibition. A state certainly has the right to regulate doctors and procedures, but I think we're kind of far afield here. What we're dealing with here is the standard of care, the gold standard in this particular type of treatment, and the State saying you can't get it. And I think what the evidence shows here is contrary to what the State is alleging. Obviously gender dysphoria is a condition within the Diagnostic and Statistical Manual. It's not caused by the internet, it's not caused by social contagion, or the result of the transactivist lobby. It's a diagnosis like any other mental health condition.

Number two, the standards, the PATH standards and the Endocrine Society standards, despite the State's unwillingness to accept them, are evidence based, and they are based on rigorous review of experts.

Number three, I think the evidence is clear that parents and their children are not being pushed into getting gender-affirming care without knowledge of risks and benefits.

The diagnosis for gender dysphoria requires six months of incongruous and distress, and no one rushes into this. The youth and the parents are being given detailed information as to the benefits and risks of this procedure, and we have included that in our materials with our response reply memorandum, the ones from Mosaic and Riley and Eskenazi, and these medications, puberty blockers and hormones, are only provided after evaluation of mental health and take into account co-morbidities.

The evidence also shows, Your Honor, that the puberty blockers have been widely used for decades -- no one disagrees with that -- to treat adolescents for precocious puberty, and also for other things, and there is extensive data supporting the safety of their use. They are prescribed, of course, in this case to prevent the distress that accompanies body changes with puberty for someone who is gender dysphoric. For instance, as K.C. approached puberty and noticed her body odor, her dysphoria increased. She took multiple baths and showers daily. She stopped looking at herself in the mirror. She obsessed that her voice was getting lower, and she demonstrated general discomfort with her body. Gender dysphoria. After less than a month on a puberty blocker, she has shown great improvement because she does not have that fear of going into the wrong puberty.

The evidence also shows, Your Honor -- and again,

this is not contested -- that the hormones that are prescribed -- testosterone, estrogen -- are widely prescribed to persons with conditions other than gender dysphoria, things like delayed puberty, hypogonadism, Turner syndrome, Klinefelter syndrome, disorders of sexual development. The side effects are rare. One of them is it may affect fertility, and you will see in the informed consent information that is discussed and options are offered. The other thing the evidence shows, that treatment works both for short-term and long-term functioning and mental health, and regret and desistance is extremely rare. We have cited numerous peer-reviewed articles and studies that show exactly that. And of course the efficacy of the treatment is confirmed by our experts who have done this thousands of times. The evidence is also clear that terminating this ongoing care and denying future care will cause severe harm -- onset of the wrong puberty, development of secondary sex characteristics for the wrong gender -- and we have cited peer-reviewed studies that demonstrate this directly contributes to poor mental health outcomes.

And lastly, Your Honor, as I alluded to, most importantly, there is no evidence-based alternatives for treating gender dysphoria. The State suggests psychotherapy -- and as I noted, Dr. Kenny in Australia practices what appears to be conversion therapy, which not only has been prohibited in

three Australian states, but it's been deemed unethical by the American Medical Association, the American Psychiatric Association, the American Psychological Association because it does harm and increases the risk of psychological distress and suicidality. And traditional therapy -- going to talk this out -- doesn't cure gender dysphoria. A.M. was in therapy through Eskenazi for almost three years before receiving her puberty blocker. Therapy by itself does not work. It can be obviously presented in conjunction with gender-affirming care but not as a substitute.

The only other alternative, of course, is to do nothing and wait until the minor turns 18. Well, this is akin to having a child who has bipolar disorder or cancer and saying, well, let's wait until you're 18. It's not a viable alternative.

So what is the law here? As we said, I think this is clearly unlawful, and courts have so found as violating equal protection, due process, the Medicaid Act, the Affordable Care Act, and the First Amendment. Let's talk about equal protection.

THE COURT: And before we get there, I just had one question.

MR. FALK: Sure.

THE COURT: You had mentioned, a minute ago, desistance.

MR. FALK: Yeah.

THE COURT: And I believe that your experts essentially say that that is virtually non-existent for individuals who are diagnosed when they are adolescents --

MR. FALK: Exactly.

THE COURT: -- as opposed to being prepubescent. There was a 2022 study in the Journal of Clinical Endocrinology and Metabolism entitled the Continuation of Gender-Affirming Hormones Among Transgender Adolescents and Adults that, among other findings, found that among the patients who began taking cross-sex hormones as minors, that there was a 74.4 continuation rate after four years, leaving obviously over 25 percent who would have stopped. So it appears as though there is perhaps an inconsistency between your experts' opinions and the findings of that journal, or a factual dispute there.

MR. FALK: I don't think so, Your Honor. I think our experts noted -- and I apologize, I don't remember which one, I think more than one -- that it's not uncommon for persons when they hit adulthood to be satisfied as where they are. They don't go back. They're not regretting their journey. They just don't feel the need to continue with hormonal care because they feel they have come as far as they need to go. That is not -- I guess it's technically desistance, but that is not regret. That is deciding that it all worked. And I think that

is what I believe Dr. Karasic testified that his experience is with his patients. Some of them are satisfied where they are. Others want to continue receiving hormones.

THE COURT: So any number of the cases could be desistance without regret?

MR. FALK: Exactly.

THE COURT: Thank you. Go ahead.

MR. FALK: In *Whitaker*, of course, the Seventh Circuit established that discrimination against transgender persons is sex discrimination for purposes of equal protection because the discrimination there, not allowing a transgender male to use -- a male student to use a high school male restroom, was discrimination based on sex. The Supreme Court in *Bostock*, of course, reached the same conclusion in the context of Title VII. In both cases the Court concluded that challenge actions could not be stated without reference to sex. Now, the State argues that the discrimination here is not based on transgender status but on age, procedure, or medical condition, but this just isn't the case. Let's assume the law goes into effect and it's July 2nd and a doctor is in her office and she has on her calendar that she has an initial appointment for a 16-year-old who requires an office procedure to receive testosterone and that's all she knows. Well, she won't be able to do it unless she knows the sex assigned at birth of the patient. She can do it if the 16-year-old is a

cisgender male. She cannot do it if he is a transgender male.

What the law allows and doesn't allow cannot be stated without reference to sex. And as the Eighth Circuit indicated in ***Brandt***, and also ***in Ladapo*** and ***Eknes-Tucker***, this is discrimination based on sex because the minor's sex at birth determines whether or not the minor can receive the care. Now, the State seeks support from the Supreme Court's 1974 ***Geduldig*** case where the Court held that denying pregnancy benefits for job loss due to normal pregnancy did not violate equal production because in the estimation of the Court this was a neutral condition that treated men and women equally, it did not discriminate based on sex. Well, the ***Geduldig*** argument has been raised and rejected repeatedly in other cases concerning discrimination against transgender persons like we hear today -- ***Ladapo***, ***Kadel*** and ***Boyden*** -- because excluding this care does not treat transgender and non-transgender persons the same and directly targets transgender persons. It is not a neutral condition. It's a facial classification based on sex, as the -- as I argued, after all, cisgender persons can receive puberty blockers and hormones. And to know whether you can receive treatment, you have to know the person's sex at birth. This is differential treatment based on sex, or at least sexual stereotype.

U.S. versus Virginia tells us that this type of discrimination, gender-based discrimination, is subject to

demanding scrutiny requiring the State to demonstrate an exceedingly persuasive justification. It must be substantially related to an important government interest. And the State argues that this serves the important government interest in the well-being of minors. It's not enough to claim it. What does the evidence show? And this is where I think parsing the experts, although we think they certainly go our way, isn't really necessary because in looking at the State's interests, the medical interventions that the plaintiffs are receiving represent the standard of care. It's backed by research and clinical experience. It was initiated -- they were initiated only after confirmation of their need and only after the benefits and potential risks were explained. This is all uncontested. They work. They work.

The State took depositions of all of the parents in this case, and they have all talked about how their children have benefited from this treatment. And there are no alternatives, Your Honor. There is no alternative to the safe and effective treatment that is being provided now.

Banning this medically-necessary care is not substantially related to the articulated interests. It's contrary to the interests. It's not minimally rational, let alone meeting the elevated standard required. It also violates due process.

Ladapo, *Eknes-Tucker*, and *Brandt* all found a

violation of both equal protection and due process, finding that this statute, or a statute like this, likely violated the fundamental rights that parents have in the care, custody, and control of their children.

As the Supreme Court noted in *Troxell*, this is a right that is perhaps the oldest of the fundamental rights protected by due process. And as the court also stressed in *Troxell*, if the parent is fit, there is normally no reason for the State to interfere or question the choices that parents make.

Obviously S.E.A. 480 is an attempt by the State to radically interfere with fit parents, in consultation with their doctors, making choices for their children that are the standard of care.

THE COURT: In the two cases you just cited there, you said that the Court had found both that the plaintiffs had proven their case with respect to due process and equal protection; is that right?

MR. FALK: That's correct.

THE COURT: But if I were, for example, to find that the plaintiffs had established a reasonable likelihood of prevailing on their equal protection claim, I wouldn't have to go on and address due process, right?

MR. FALK: That's correct. And that's exactly what the Eighth Circuit did in *Brandt*. The district court in *Brandt*

found that this was a violation of parental rights, equal protection, and also the First Amendment. And without mentioning those other claims, the Eighth Circuit said that this was an equal protection problem.

THE COURT: And let me ask you one question on the First Amendment claim, since you mentioned that there was just kind of a natural follow-on. If I were to agree with your position on the merits there, it would be too vague, I think, for the injunction to just say it's enjoined as to speech. So is there specific language that you have thought of or that you would propose that the injunction would actually have that would address that topic that would be specific examples of speech that would be covered?

MR. FALK: Well, the problem, the First Amendment problem is because we have this aiding and abetting provision, and the aiding and abetting provision prohibits Mosaic and Dr. Bast, for example, from, after July 1st, if the law was in effect, to refer their patients out of the state or to answer questions from out-of-state providers, so to the extent that that is banning pure speech, which it clearly is, then we would ask that the law be found to violate the First Amendment to the extent that it would prohibit communications by, in this case, the physicians or by the clinics. It obviously would not prohibit, perhaps, actions being taken, but at this point all we're talking about is pure speech, so I'm not sure -- we would

certainly be happy to propose language, but that is what we're talking about, and that is what -- you know, this is, as we noted for the First Amendment, this is the ***Bigelow*** case where the State of Virginia said not only can you not do abortions here, but you can't even advertise legal abortions in New York, and the court struck that statute down. We think the statute here is indistinguishable in that regard.

THE COURT: So I think we're probably at about a good place where I would like to hear from Mr. Fisher soon, so if you could wrap up where you were going in this front end of your presentation, that would be great.

MR. FALK: I would be happy to do so. We think this is a clear violation of parental rights. This is, as we noted, a fundamental right that has been long recognized as a violation -- or as an impingement on a fundamental right. There must be a compelling governmental interest narrowly tailored. Again, for the same reasons I alluded to, there is no justification for this law.

And just very briefly, the Medicaid Act claim, which has been recognized in other cases, is quite clear. Medicaid requires not just that the State pay but that the State provide services. This denies that. And because Medicaid is implicated, which is federal funding, the Affordable Care Act is implicated as well, and therefore denying Mosaic, Dr. Bast, and other practitioners the ability to provide these services

when they are Medicaid recipients is discrimination on the grounds of sex, as found in other courts, and it violates the Affordable Care Act.

THE COURT: Okay.

MR. FALK: Thank you.

THE COURT: Thank you.

Okay, Mr. Fisher.

MR. FISHER: Thank you, Your Honor. May it please the Court. So I'll start, of course, with the oral motion to strike our motion to exclude. A couple of responses I think are warranted there. First, with respect to our stipulation about the receipt of evidence in this case, I had not understood that to cover things like Rule 702 motions based on reliability. I had understood it to cover the idea that we don't need to bring the witnesses into court to have them testify. And we had flagged in our motion to push off the class certification briefing that we were considering a *Daubert* motion, and that was one of the reasons that we needed additional time. Now, once we filed our brief, we scrambled as quickly as we could to get the motion to exclude on file given the, you know, the complexities of the witness testimony, the need to corral our own experts to get their reactions to it. And, indeed, even the supplemental expert reports that the plaintiffs filed that brought in new evidence, brought in new testimony, all of this contributed to the timing, so I think --

you know, I think what we have done is reasonable, and I think the plaintiffs are incorrect that at a preliminary injunction hearing reliability doesn't matter. I think, you know, notwithstanding the form in which it comes in, I think the reliability of opinion testimony always matters, even in a bench trial. So that's -- in summary, those are our responses on the motion to exclude. You know, I think there is a lot there to take in.

And candidly, I completely understand the Court's concern about the back-and-the-forth over the experts, and I really don't plan to spend time on our experts today. I want to talk about the European systematic reviews, which really are not in any way contested by the plaintiffs. They don't -- their experts, when given a chance at depositions, refused to say that those reviews were unreasonable. In their reply brief, knowing how much we were relying on those systematic reviews, they didn't address them, and I think that that is really, in many respects, kinda the safe area for the Court if you don't want to have to get into the questions about reliability of the experts, the questions about their biases, the questions about their affiliations, and I think that provides a lot. Those are, you know, government-commissioned reviews that are specifically designed to factor out things like bias and cherry-picking and the, you know, overlooking of confounding variables. They are meant to assess the quality

and not just the quantity of evidence.

And so I think, you know, let's take a look at what a couple of them say on this subject. In Britain, where blockers, by the way, blockers and hormones had been available to youths since 1989, they commissioned -- the UK National Health Service commissioned a report by Hilary Cass, and she said that using the -- what we have described and what others agree as sort of the standard to be applied here, the GRADE standard for quality, G-R-A-D-E is the acronym. Using GRADE, that report concluded that those interventions, the evidence supporting those interventions, was very low quality, which means any estimate of effect is certain or that the true effect of an intervention is probably markedly different from what the study purports to find.

The NICE assessment by Dr. Cass also observed that children taking puberty blockers lack normal bone density. Dr. Cass reported that the review could not provide definitive advice on puberty blockers and hormones due to gaps in the evidence, and the evidence was not strong enough to recommend a policy. Dr. Cass, interestingly enough, also highlighted that the literature provided the least information for the largest group of patients, namely females present -- first presenting in the early teen years. And this is a theme that I think comes up again and again in the European reviews and with the literature that our -- certainly our experts have cited about

this growing number of a different age and sex cohort than what had traditionally presented for gender dysphoria in the past.

Now, what has been the UK's response to the Cass report? Well, they --

THE COURT: Well, wait, wait. I have a question on the contagion since you brought it up.

MR. FISHER: Uh-huh, sure.

THE COURT: Isn't it equally possible or even probable that the increase in social acceptance, and things along those lines that are argued by the plaintiffs, is what is responsible for the increased number of patients who are in that category, as opposed to the theory of social contagion?

MR. FISHER: Yes, certainly. I think the critical issue here is we don't know. And in that regard, let me just point you very quickly to what the Norwegian systematic review said, and this is reported -- and I don't take plaintiffs to contest this, but Dr. Cantor reported this in his declaration, and in the Norway report we have the Ukom medical director Stine Marit Moen saying that we have seen a marked increase in referrals to specialized health care services in Norway for teenagers, as seen in many other western countries, and nobody knows the reason. And that is really important, that we don't know the reason. Is it something that is going to be a permanent sense of gender dysphoria if it's not treated with hormones and blockers? Is it something else? We don't know.

And in particular that's relevant because the studies that have been done -- which by the way do not show any causation, any causative benefit from hormones and blockers -- were done on different cohorts, typically young men presenting for a long period before they hit their teenage years, and that has been I think one of the alarm bells for a lot of people who look at this now. This is a very different phenomenon that is coming across, and we just don't know the answer why.

Now, Britain's response to the Cass report has been to say that -- and this is just as of last Friday, even after we filed our brief, unfortunately. The UK National Health Service announced two new protocols. It said that the primary intervention for minors with gender dysphoria would now be psychosocial and psychological support and intervention. That's the alternative. That's not what the plaintiffs have described as conversion therapy. Not everything that doesn't support gender-affirming care is conversion therapy. That's been the complaint lodged against our experts is that, well, if you don't support blockers and hormones, if you support psychosocial support, you must be a conspiracy therapist and a conversion therapist. And that is not fair, and that is not accurate. That is Britain's policy change. They have done a 180. Before, routinely hormones and blockers were recommended. Now it is not to be routinely recommended.

I mentioned Norway also --

THE COURT: Wait, so as far as the psychotherapy goes, of course your argument with respect to the plaintiffs is that there is no reliable evidence that blockers and cross-hormone therapy are efficacious.

MR. FISHER: Right.

THE COURT: Is there data supporting your view that psychotherapy is efficacious and has a certain outcome?

MR. FISHER: I think -- first of all, let me just take it in general, which is to say with respect to any number of psychological disorders, depression, PTSD, many other, you know, types of disorders, I think cognitive behavioral therapy, other psychological therapies, are highly regarded, well understood to be very effective. Now, in this context, do we have a study? No. You know what, the studies that the plaintiffs rely on typically were combining psychological support with hormones and other -- and medical therapy, so they were together. They have never been disentangled. The difference is that psychosocial support, cognitive behavioral therapy, does not pose the same risks, long-term risks, as intervention with blockers, with hormones, and with surgeries, you know, risks to bone density, risks of any number of diseases, risks to fertility, those things are not at stake with psychosocial intervention, so I think there is a very big difference when we compare those two.

THE COURT: And on the topic of risks associated with

those treatments, I know that your experts, of course, cite the possibility of risks, and it seems like there are risks attendant to virtually any medical procedure you could have.

MR. FISHER: Uh-huh.

THE COURT: The plaintiffs, I think, argue that those are mitigated by individual treatment, as well as informed consent. But my question for you would be is there any evidence that the defendants have that quantifies the risk, or is just a very general there is a risk, so that means it could be a .1 percent risk or anywhere between there and up, or is it completely unknown?

MR. FISHER: Well, I'm sorry, I can't bring up an index of those specific risks and what they are, but I think that our experts pretty clearly do point out studies showing quantifiable risks of various types, so I think they are quantifiable. And there are various types of risks, including fertility, which is very high, in fact is something that is almost unavoidable when you go from blockers where your reproductive organs don't develop, straight into hormones, and the idea that you are then at some point going to come off of hormones and be able to have reproductive capacity, it's hard to see how that could happen. And certainly there is no evidence about that, and that is a very important risk that, you know, given the trajectory that we see where once you are on blockers there is this sort of conveyor belt where you then

get onto hormones and eventually you go to surgery, that's a very serious problem. But the other risks, yes, are quantified and quantifiable. I don't even think at some level that they are denied. I mean they are disclosed as part of the informed consent process. And the question really then is, well, how do we make an assessment as to how much risk is too much for a minor to undertake? That is a classic government regulatory question, and I think it's really interesting that Mr. Falk has said, well, gosh, if we would merely codify the WPATH standards or the way that IU Health and Riley do things, that would be acceptable regulation. Well, why are those the entities that get to determine what is acceptable regulation in our society?

THE COURT: Let me ask you one question on the prior topic before you continue down this path, which I am eager to hear more about. But when you cited the defense experts' studies relating to harm that -- or the likelihood of harm resulting from the use of blockers and/or hormones, are those based on randomized controlled trials?

MR. FISHER: Offhand I don't know the answer to that, but the expert reports themselves set forth -- and again, I don't think that the risks and those quantified risks are disputed. I think that everybody understands that they are there. It's just a question of what you do with that, and I think that from the plaintiffs' point of view we can make decisions individually knowing that those risks exist, as long

as they are disclosed, and our position is, well, when you are talking about minors and when you are talking about long-term effects and the ability -- you know, the inability to know the benefits of this intervention, those risks are very important, and they justify government intervention.

So, again, why isn't it, you know, the State of Indiana and our legislature that can look at these European systematic reviews, they can come -- see those conclusions and make a regulatory decision. And in fact, the plaintiffs criticize us for citing those studies only because those countries have not enacted an outright ban the way that we have. Well, they have made very substantial policy changes. And again, this is a matter of regulatory judgment. What do you do with the information? The information is not, as far as I can tell, disputed from the -- in terms of what has come out of these systematic reviews. What the Indiana General Assembly has decided to do is to say we don't want our children to be part of this grand experiment. If they want to have availability as part of research programs in the UK or in these other European countries, they can do that. We don't have to do that. That is certainly not something we think is appropriate for children here.

So again, that all comes down to politically-accountable legislative judgment, what do you do with the information, and the WPATH and others who have come

forward with guidelines do not get to determine what is the constitutional limit of the regulatory response.

Now, you know, I invite the Court to look at the other reviews, including especially Sweden, which has a very compelling report, and even there the Karolinska Institute, which was one of the world leaders in interventions for minors for gender dysphoria, has reversed its policies, and it no longer provides puberty blockers or hormones to anyone under the age of 16, so there we have a very respected institute taking this information, seeing that there is an absence of long-term studies and there is a presence of risk and there is no evidence of causation and coming to a decision that, you know what, we're going to put the cutoff at 16, and I think -- you know, we choose 18 in Indiana. That's, you know, hardly a constitutionally-significant difference.

So I invite the Court, again, to look at those studies. I'm happy to talk about them more, but I also want to make sure that I address some other points that the plaintiffs raise.

So the plaintiffs talk about WPATH and the Endocrine Society and all of these other societies that have endorsed what they describe as the standard of care and this is the standard of care. There is nothing talismanic about the standard of care. The State is permitted to regulate the standard of care, so that doesn't really tell us much when we

arrive at some conclusion as to what the standard of care is. But what is interesting is that WPATH's guidelines, the latest guidelines, the SOC-8, do not purport to be based on a systematic review the way that those European studies are. SOC-8 thinks that you can't do a systematic review precisely because the studies don't exist. Well, that's supposed to tell you something when you go to do a systematic review. If you can't find the studies, maybe you have got something to be concerned about, maybe you need to start back a few steps before you assume that, you know, there is something worth trying out here, so -- and SOC-8 instead relies on literature that it selects -- again, there is this cherry-picking problem that systematic reviews are designed to address -- and professional consensus, which is really the weakest type of evidence that lies at the bottom of the evidence pyramid. SOC-8 does not even disclose how the literature it cites scored under GRADE or under any other scoring system for reviews or where it is allowing consensus to override the evidence.

In fact, the lack of quality evidence supporting the guidelines is apparent by the process that they used. As part of the process, WPATH commissioned a review by Baker in 2021, but that review asked only limited questions about the effectiveness of puberty blockers and hormones. It did not consider safety, which is a critical question. And despite that limited scope, the Baker review was unable to identify a

sufficient number of studies focusing on adolescents to support results for minors specifically. And when combining adolescent studies and adult studies, the review reported that it was impossible to draw conclusions about the effects of hormone therapy on death by suicide. That is one of the very important risks that the plaintiffs are relying on when saying that an injunction is necessary, here is this prospect of suicidality. Well, even WPATH was unable to come to a conclusion about the effect of hormones and blockers on suicidality.

Well, what about the Endocrine Society, does it do any more to support the idea that the WPATH guidelines or this general standard of care is supported by evidence and can be considered evidence-based care? And they do not. They were drafted by a committee largely staffed by WPATH leaders and authors, and they are not supported by a comprehensive systematic review either. The society never claims to have reviewed any evidence regarding whether medical interventions are effective in reducing gender dysphoria or improving mental health, nor does the society claim to have undertaken a systematic review regarding the risks of medical interventions for fertility, brain development, and reversibility, even though it admitted that those were risks. Rather, the society commissioned reviews on just two narrow questions, lipids and cardiovascular outcomes and also bone health, but their failure to look at the critical risks is a serious problem with the

guidelines. Why wouldn't a comprehensive assessment of the science go into the known risks, those that even the Endocrine Society itself recognized exist?

So there is other vary -- various problems. The guidelines themselves, in fact, look at the evidence that is out there on these matters, on the quality of evidence for recommending hormones and blockers, and they rate it as low or very low under the GRADE standards.

THE COURT: When you -- when you were talking about the legislative judgment made, based on European studies and essentially said that there is a very, very wide range of options that the State could take in response to this information, that sounds like we're talking about rational basis review, as opposed to heightened scrutiny.

MR. FISHER: Uh-huh.

THE COURT: Is that correct? And if so, what about heightened scrutiny, and specifically the language of the fit, because that is something that I have spent a lot of time thinking about, both what is the standard that would apply, how *Whitaker* would not be a controlling case, which it seems to me that it is, and if it is, how does the complete ban on the procedures have a tight fit that would pass heightened scrutiny?

MR. FISHER: Right, well, so, *Whitaker*, *Whitaker* is, I think, first of all, nowhere near this type of regulation.

There we were talking about a school bathroom policy that drew distinctions based entirely on sex. This is a distinction here that is geared towards procedure.

And let's take Mr. Falk's example in that regard. That doctor who has a 16-year-old coming in for some sort of hormone therapy better know the sex of that child before prescribing those hormones, I don't care about S.E.A. 480 or anything else. Hormones are going to have different effects on males versus females and you have got to know as a doctor what you are treating and how much to give and how frequently to give it. That's not sex discrimination. That is taking into account immutable, physical, objectively verifiable characteristics that are biological, that is all this law is doing, the exact same thing, whereas in ***Whitaker***, the bathroom policy was based entirely on sex and not on inherent biological differences.

So I think, you know, looking at the Supreme Court precedence, whether it's ***Glenn*** or ***Geduldig*** or ***Dobbs***, all of these cases tell us where you have got inherent biological differences, those are not to be taken as discriminatory based on sex if you have a regulation that is relevant to those characteristics. Indeed, that's not stereotyping, which is the other problem with the ***Whitaker*** -- or the problem the ***Whitaker*** court found with the bathroom policy. It determined that what was going on there was an assessment of stereotypical attitudes

towards privacy, and it was discriminatory to make that kind of assessment based only on sex. This is not a statute that turns on stereotypes. Again, it turns on the procedures, the age, and the conditions for which they are prescribed, which are different from the conditions for which blockers and hormones can be used for a central precocious puberty or for problems with, you know, pubertal development, et cetera. Again, you are treating different conditions with different types of hormones for different periods of time with different results and you are knowing in those circumstances something about causation, which we don't know here.

So, again, we have, I think, a very different scenario. We don't have immutable characteristics in those other cases, and we have, I think from ***Whitaker***, merely an assessment of a bathroom policy that has really very little to do with the type of risks and the type of biologically-based, you know, medical interventions that are at issue here.

Now, I think with respect to that heightened scrutiny, we do have the evidence to meet that. I don't think the plaintiffs disclaim that the State has a compelling interest in protecting children and safeguarding their health and safety, and here the evidence amply supports advancing that interest by prohibiting gender-transition procedures for minors. We don't have evidence that those procedures work. That's one of the problems. We do know that there are

significant risks. The risks are substantial, and they are various. We detail them in our brief at pages 22 through 25, so there is probably a little more precise numbers there, but the point is that we have all of these reputable studies that I think are not -- they are not really contested from -- at least the ones from Europe and the risks themselves aren't contested and the question is, that the plaintiffs raise, well, this is not sufficiently narrowly tailored, and I think this goes to Your Honor's question about fit. Well, what are we supposed to do? We don't know -- and I don't think the plaintiffs dispute this -- which children are accurately diagnosed with gender dysphoria and which are not. There is no objectively verifiable way to say who has really got it and who doesn't. The plaintiffs' expert witnesses admit that. There is no objective test you can do. It all depends on the child's inner sense, in a way, and how it relates to the world around them. That's not something that we can have a test for and a statute, so we are left with nothing that is more finely tuned.

I think the plaintiffs' next objection is, well, you could permit it for research, but I don't understand how that that's a narrower, you know, rule that would somehow still advance the purposes of the statute. The children that participate in research trials are also at risk, the same way that all other children are, so our interests are still at stake, and we're not, as a state, required to permit the

children of Indiana to be subjected to this grand experiment, particularly when we know from the European studies that they are already happening elsewhere in the world. So I think that the narrowness of fit matches the scope of the risks, it matches the lack of proof that these are effective interventions.

THE COURT: And when you say the lack of the proof and the evidence and I think in your brief that you say that there is -- something to the effect of that there is no evidence whatsoever that the use of blockers and/or hormones has any benefit to any person whatsoever, so essentially you are saying that the evidence of plaintiffs' experts -- and I know it goes to your motion, but, again, at least one of the experts, I think it's Dr. Karasic, has been practicing in this field many, many years, seen hundreds and hundreds of patients, and is your argument that that evidence should be given limited value or that it has zero value whatsoever? Same question as to the evidence of the named plaintiffs in this case and the affidavit of Dr. Bast having spoken to her patients and saying that here is my observation, so is your argument that all of those different types of evidence are entitled to zero weight whatsoever?

MR. FISHER: Well, I will start with Dr. Bast and Mosaic because I think the important part there is that, you know, a clinical setting, a personal physician's observation

about a handful of patients, is not how we do science, it's not how we do assessment of risk and cause and effect in medicine. We don't say, well, it seemed to work okay for these patients right now, so therefore it must work. Well, we don't know anything about other patients and other circumstances, we don't know long term how it's going to work out for these plaintiffs, all we know is sort of a snapshot in time about an observation of very limited use, really, from which generalizations cannot be drawn. And I really don't think that even the plaintiffs would say that that is enough to say, well, therefore this should, you know, be deemed as successful for everybody. I think they really try to turn to something more -- something broader, and I think this is where Dr. Karasic and Dr. Turban come in. To the extent that those experts are saying that there is evidence that puberty blockers and hormones and surgeries cause gender dysphoria to dissipate, cause gender dysphoria to dissipate, they are entitled to no weight because there is no evidence that that is true. The only studies that exist, at most, show correlation, which is not causation, they don't disentangle the medical intervention from the psychological intervention and support, and they don't show what happens, you know, for a long enough period of time. And indeed, I don't think that those experts say otherwise. I think what they are trying to do is to say, well, we have these correlational studies and we have enough of them that, boy,

that sure seems to add up to causation, plus in our clinical experience this all seems to work out okay. But that, again is not how we do science. That is not demonstrative proof of causation. That is only, you know, no better than the studies that they rely on one by one by one. Dr. Turban admitted no single study shows causation, and I think that that's the critical feature of all of this.

THE COURT: Right, and I agree and I understand the point that we don't have what you refer to as the gold standard, but we have what we have, and we have to look at that evidence, recognizing that we don't have the results of randomized controlled trials on either side, so we're having to do imperfect comparisons, I guess I would say. But having to look at what evidence we do have in this record in this case, even if it's not the best, I don't think I would say, well, because it's not the best evidence that one could possibly want, it's worth nothing.

MR. FISHER: Well, no, I think the statements are worth nothing. When the statements are that intervention by hormones and blockers cause gender dysphoria to be relieved, there is no support for that statement. And the question is can the State therefore prohibit their use in light of the known risks, and the answer is yes. That's the difference. Now, as to the ability to do a randomized controlled trial, again, I think here the European studies come into play. I

think it was the Swedish study that -- you know, there can be a way to do a valid randomized controlled trial that is ethical. It has to do not with giving people placebos but with sorting them as between people who take -- medical intervention and psychological support, versus a group that only does psychological support. So I think that there is a way to do it, it hasn't been done, I'm not sure why, but that's where we are. And given the risks, and given that these are minors and that the risks are not short term but long term and that the risks, even in a successful scenario, we're talking about a lifetime of medicalization, potentially surgery that is going to irreversibly damage, you know, one's reproductive organs or other -- you know, perhaps breasts, I mean this is really serious stuff, and I don't think it's like more minor medical interventions that can rest on less rigorous scientific scrutiny.

Again, where is that line going to be drawn between what the legislature can regulate and what it can't regulate based on the science of efficacy and the science of risks? Classic legislative question. There is no constitutional or statutory line to be drawn here.

THE COURT: If this were rational basis.

MR. FISHER: Well, I think, yes. But I think that even if we are in heightened scrutiny, we have no proof of benefit at all. There is no proof of causation, and that's, I

think, critical on that inquiry.

THE COURT: I believe it is undisputed in the record that adolescent gender dysphoria is a serious medical condition recognized by the DSM-5, right?

MR. FISHER: Right.

THE COURT: Okay. So we agree with that.

And a focus of that, as I understand it, is on the distress that individuals diagnosed with that condition may experience. So my point is that we're talking about the real, live individuals who have been diagnosed with what is a real condition validated in the DSM-5. And would you agree that if left untreated, that an adolescent can experience serious harm from having gender dysphoria that is untreated?

MR. FISHER: Perhaps. But of course no one is talking about leaving this untreated. The question is not hormones, blockers, or nothing. It's what is the, you know, the ability to get other treatment, psychological support, psychosocial support. Which, by the way, Dr. Karasic acknowledges is valuable, at least in cases of suicidality. Well, if it's valuable there, why isn't it valuable in other places?

Let's take one of the concrete examples to illustrate this point. One of the plaintiffs, M.R., there was a mental health hospital visit. Mental health hospital treated M.R. who suffers from anxiety, depression, and ADHD. The treatment that

was prescribed by the hospital was anti-depressants and teaching M.R. coping skills. M.R. reported good results. M.R.'s doctor suggested that providing continued mental health support would be a treatment option, but M.R.'s mother already decided, before seeing the physician, that M.R. would start hormones as well. After starting hormones, M.R. stopped taking anti-depressants. So the rush to hormone therapy there interceded, got in the way of, the alternative, which is the anti-depressants and the psychotherapy that was prescribed by the hospital and that M.R.'s doctor had recommended to be continued. So it's not a case of all or nothing. There is an alternative, and that alternative is the psychological care that accompanied the inventions with hormones and blockers in all of the studies the plaintiffs cite, which cannot be discounted as the causation that's behind whatever recovery those plaintiffs found.

THE COURT: So let me shift gears just one second and ask you about on the issue of ultimately granting injunctive relief, assuming that I were to find that plaintiffs had established some likelihood of succeeding on one or more of the claims and had passed the initial phase of preliminary injunctive relief, my question would be is it would seem like you have a group of adolescents who are going to have to abruptly stop a course of treatment that they have been undergoing for some amount of time and there is evidence from

the parents, the minors, and the doctors, that that would cause those specific individuals harm. And I also note somewhere in the plaintiffs' materials they gave the data that I think Riley Children's Hospital has been providing this type of treatment since about 2018 to over 900 patients and that a good number of them have received or are receiving blockers and/or hormones. Long way of leading up to ask that wouldn't the harm that is going to occur to those individuals who began undergoing this treatment, without any idea that it would be abruptly stopped, would outweigh any comparable harm?

MR. FISHER: So a couple of points I want to make in response. The first is with respect to hormones, it's not that immediate. It doesn't -- there is a taper period to the end of the year. With the blockers, it does go into effect immediately. With the hormones, it's until the end of the year, so it's not as immediate and as abrupt, so I just want to make sure that that is clear.

THE COURT: No, right, I understand that, but they will have a finite amount of time where they will be faced with, I suppose, if the law were to go into effect, where they would have to say either they immediately cease doing treatment that their parents and they and their doctor have all agreed that was medically necessary under their individual circumstances, or I suppose leave the state. So if my ultimate goal is to get it right, wouldn't I want to leave the status

quo as it's been while this case is pending until we can actually have a full trial on the merits, which will be a bench trial, obviously, because they are only seeking injunctive relief, and get that done soon?

MR. FISHER: Well, I think a couple of points. Number one is the types of comparisons that I think the Court is making between these particular plaintiffs and other plaintiffs perhaps that are being seen at Riley or other places, I think all of that has to be assessed in the context of the motion for class certification. I don't think that that is something that the Court can skip over and craft an injunction that is so broad that it covers every conceivable patient that maybe Riley or these other facilities have, and I think the Court and the Seventh Circuit has been quite clear about that, that you have to tailor the relief to the particular plaintiffs.

Now, in a circumstance where there is a final judgment and a broad declaration of invalidity, that is a very different scenario, and it's not really that there is an injunction as against the whole world absent class certification, but it's just that the declaration of invalidity does the work of sort of the universal application.

In the preliminary injunction scenario, we don't have that. We have to focus on these plaintiffs. Now, if we go through the class certification scenario and the Court is

satisfied that all of the requirements for class certification have been met, that is, again, different. But the Seventh Circuit tells us, with respect to this preliminary injunction right now, the Court can only really address the harms that are attendant to these plaintiffs.

Now, again, I think what I want to point to, of course, is the lack of evidence that these interventions are causing any relief from gender dysphoria. The Court, I think, you know, and other courts have said, well, gosh, there is evidence that these interventions work for things like blocking puberty, for prompting secondary sex characteristics or preventing other secondary sex characteristics. And of course all of that is true, but that's not the question. The question is what's the effect on the dysphoria. And there is no evidence that these interventions cause a relief from dysphoria, as opposed to other interventions, namely psychological interventions, and all of what has accompanied, I think, so many of the treatments of patients having gender dysphoria for so many years. So I think that that is part of what the Court has to think about and has to look at.

Now, I would submit we're presumably, if the Court grants an injunction, which I hope it won't, but if it does, then we're going to proceed to, I would assume, the class certification motion, and at that point I think, you know, the Court will be able to take into account the broader impact and

review whether, indeed, these plaintiffs are representative in a way that is significant and meaningful enough to expand that injunction.

THE COURT: Okay. So based on our timing here, I think I'm going to momentarily go back to hearing from Mr. Falk, so if you could wrap up your presentation.

MR. FISHER: And really I think at this point I'm only interested in answering the Court's questions. I think Mr. Falk briefly touched on Medicaid, and so I shouldn't let that go unaddressed. This is not a Medicaid statute. This is a statute that has to do with regulating the practice of medicine. If Indiana targeted treatment of Medicaid patients, that would be a different thing, but that's not what this statute is doing, and that gets us outside of Medicaid. There are no cases that I'm aware of, aside, perhaps, from the other gender dysphoria cases that Mr. Falk is relying on, no other cases that say, well, Medicaid prevents the State from regulating broadly with respect to the practice of medicine, and so I think that that is really a non-starter in terms of a way to preempt Indiana from doing what it's doing here.

THE COURT: All right. Thank you.

Mr. Falk.

MR. FALK: Thank you. In one sense the argument the State is making is shocking. They're saying there is no evidence, even though we have submitted countless studies and

even though we have experts who have seen thousands of persons, they are saying there is no proof that there is causation. And what our experts have said is that what there is is proof that this is efficacious, that this works, that without this treatment, people get worse. I think we're asking a lot of science here. Listening to clinical judgment as medicine is exactly how we do medicine and the fact that something has worked thousands of times means something and the fact that we are dealing with a standard of care that has been endorsed by everyone means something. It would be shocking to a doctor practicing to find out that, hey, you know, forget about listening to the AMA or the American Psychiatric Association, the American Academy of Pediatrics, because the State of Indiana is going to tell you what to do. There has to be a significant reason for that, and there isn't there.

Mr. Fisher talks about what is going on in Europe. What is going on in Europe is that you are having countries say that perhaps it will be harder to get gender-affirming care through the National Health Service, but in Sweden today you can get gender-affirming care from a private doctor, in England you can get gender-affirming care. No one, no one, no country has banned this care. Indiana is going where Europe has not gone/done. And for Indiana to say, well, we need more research, well how do you do research, Your Honor, if you ban it? Our experts are scientists. They are more than happy to

do studies, they are more than happy to do research, but you can't do research if you can't do the gender-affirming care.

Now, Dr. Karasic has noted that most pediatric treatment is given a very low GRADE in systematic reviews because generally low quality means no random controlled trials, so I don't want to play doctor, I don't want to play social scientist, but I don't think we can draw conclusions by talking about GRADE and low GRADE. I think we can draw conclusions from clinical experience. And obviously, that's what our experts have, and their credibility depends not on their demeanor, which you can see, but on their obvious experience they bring to bear, and our experts have brought a lot of experience to bear.

But this is not a case about dueling experts. This is a case about whether the State can show that this discrimination, which is clearly based on sex, survives heightened scrutiny, and it simply doesn't. The State hypothesizes potential harms, but there is no proof of the grave harms they talk about. Yes, there is a bone density potential issue with puberty blockers and that's why you see in the material that we presented from Riley and Mosaic and Eskenazi that's dealt with and there are ways to deal with it through monitoring, through providing a medication, through making sure someone is not on puberty blockers for too long. This is the exact same risks that you have if you are getting

puberty blockers for something else. Yes, there is a potential risk concerning fertility with regard to hormones, although our experts note that people who are on -- transgender persons who are receiving hormones are informed to use birth control because you can still get pregnant or can still be fertile, but there are ways to dealing with that too. Every medicine has a potential downside. And what medicine does, and what we trust our doctors to do, is to sit down with us and say, look, here is the problem, you have gender dysphoria. Yes, there is no objective test for gender dysphoria. There is no objective test for depression, for bipolar. The Diagnostic & Statistical Manual of Mental Disorders is full of mental disorders that there is no objective test for, but there certainly is an objective listing about gender dysphoria so that practitioners can diagnose you, not based on this is just what we think, but based on meeting standards that have been vetted and have been approved and are used every day.

So they sit down, and they say here it is, you have gender dysphoria, here are your options, here are the downsides, here are the plus sides. I think what our experts have testified from their clinical experience, experience that defendants' experts don't have, is that in weighing those downsides against the upside of getting rid of or minimizing dysphoria, again the upside of aligning yourself -- you know, let's not miss -- let's not forget about how horrible gender

dysphoria is, how horrible it is to be trapped in the wrong body, and how that permeates every minute of your life and every minute of parents' lives, so you are able through this discussion with your doctor to assess the plusses and minuses and then most people say, yeah, let's try it because we need to feel better, and we do feel better. People feel better. This isn't a case where four people are getting treatment. This is a case where thousands of people in the United States are getting this treatment, and there is a long history of providing this treatment.

We could always use more research, sure. And we are willing -- our experts are willing to do it if they can provide this sort of procedure.

Mr. Fisher mentioned M.R. M.R. was hospitalized for suicidal thoughts and behavior -- I think he had been cutting, suicide ideation -- after being repeatedly misgendered for quite some time in his school and trying to cope with that. His hospitalization was directly related to gender dysphoria. In the hospital, he is diagnosed with gender dysphoria. And coming out of the hospital, he seeks treatment for gender dysphoria, continues his medication, I think Dr. Bast prescribed him a different medication for depression, but that's how it works. That's how it works. You have gender dysphoria, and it's hard to reconcile yourself with your day-to-day life. And with his hormones, he has improved.

There are enormous stakes here, Your Honor, for these children and their families, and I think that a parent can tell you those enormous stakes better than I can. When M.W.'s mother was asked what her worries were, she was asked in her deposition about this statute, she said, quote: That he will be denied the care that has breathed life into him, and it could all get taken away from him. That would send him back to the darkest period and worse because he has had a taste of what life could be like when he has that alignment within himself, and to rob him of that would be devastating.

We think that this Court should maintain the status quo and grant the injunction. We are happy to have a quick trial to resolve this, but it would be truly, truly dangerous and devastating to end this treatment for the many hundreds, if not thousands, of persons in Indiana who are receiving it now. Thank you.

THE COURT: Okay. Thank you. So I do want to thank both sides for very thorough and professional presentations, both on paper and here today in court, that very thoroughly address issues that, of course, as Mr. Falk and Mr. Fisher indicated, are of great importance to both sides in this case. I will take the motion under advisement. I'm aware, obviously, of the time sensitivity with the effective date of the new statute rapidly approaching, and we'll get a ruling out as soon as possible.

Is there anything else, Mr. Falk, at this time?

MR. FALK: Your Honor, their motion to exclude is sitting out there. We have 14 days to respond under the local rules. We have moved to strike. Obviously we would prefer not to respond to it because we don't think it should exist, but what is the Court's pleasure in that regard?

THE COURT: I will issue a written order following up before the end of this week, so I have both under advisement at this time.

MR. FALK: Great. Thank you.

THE COURT: Anything further?

MR. FALK: Nothing. Thank you very much, Your Honor.

THE COURT: Mr. Fisher, anything further?

MR. FISHER: Nothing, Your Honor. Thank you.

THE COURT: Okay. So thank you all again. And with that, we are adjourned.

COURTROOM DEPUTY: All rise.

(Adjourned at 2:59 p.m.)

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CERTIFICATE OF COURT REPORTER

I, Jodie Franzen, hereby certify that the foregoing is a true and correct transcript from reported proceedings in the above-entitled matter.

S/s Jodie Franzen